(XS) COMPLETION DATE

08/27/2010 FRI 14:35 FAX 6158901224 MHC HEALTHCARE PAGE 04/21 PRINTED: 08/16/2010 HEALTH CARE FACILI 8655945 08/17/2010 09:09 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: a building 08/11/2010 B, WING 445108 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 N UNIVERSITY ST MURFREESBORO, TN 37130 NHC HEALTHCARE, MURFREESBORO PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX TAG DEFICIENCY) TAG F 000 F 000 INITIAL COMMENTS An onsite visit was conducted during the annual recertification survey on August 9, 2010, thru August 11, 2010, at NHC Murfreesboro to investigate c/o #26217, 24872, 24197, 26082, and 26151, no deficiencies were cited related to the complaints. 483.10(n) RESIDENT SELF-ADMINISTER F 176 F 176 F 176! DRUGS IF DEEMED SAFE SS≍D Resident # 8 was assessed for self An individual resident may self-administer drugs if administration on the nebulizer medication on 8/18/10. All patients the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this receiving nebulizer medications will practice is safe. be assessed for self administration by 8/27/10. In-services were conducted This REQUIREMENT is not met as evidenced by the DON for the Licensed Nurses on 8/16/10, 8/17/10, 8/23/10, and by: Based on medical record review, observation, 8/31/10 regarding self administration and interview, the facility falled to assess for of nebulizers and observation of self-administration of medications for one (#8) of patients receiving nebulizers. The thirty-three residents reviewed. DON or her designee will conduct a The findings included: quality assurance study regarding nebulizer medication administration Resident #8 was admitted to the facility on July 21, 1998, with diagnoses including Closed Head monthly for 3 months and then Injury, Seizures, Persistent Vegetative State, and continue at the discretion of the Quality Assurance Committee.

Organic Brain Syndrome.

Medical record review of the Minimum Data Set dated May 7, 2010, revealed the resident was comatose and dependent for all activities of daily living.

Medical record review of the June 2010, physician's recapitulation orders, signed by the physician on July 14, 2010, revealed the resident was to receive Atrovent (bronohodllator) unit dose LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(XS) DATE

8/31/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days.

outer sarryusing provide suggestion in the patients, tode insurements, except or invising notices, the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evallable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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HEALTH CARE FACILI.

PAGE 05/21 PRINTED: 08/18/2010 FOND APPROVED.

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MIL A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
,	•	445108	B. WIN			08/11	/2010
	ROVIDER OR SUPPLIER ALTHCARE, MURFRE	ESBORO		420	et address, city, state zip code on university st irfreesboro, tn 37130		
(X4) (D PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DOIND RE	DATE
E 246	Medical record revithe resident had be self-administration. Observation on Aurevealed the resident's mouth. Continuity treatment. Continuity treatment. Continuity treatment of the nebular self-administration and it 3:10 p.m., with Lic #2, revealed the resident's mouth. Observation and it 3:10 p.m., with Lic #2, revealed the resident in the resident in the resident approximate observation. Continued the resident approximate of the resident approximate of the resident has the services in the fact accommodations preferences, except the individual or of endangered.	iew revealed no documentation een assessed for of medications. gust 9, 2010, at 3:05 p.m., ent.sitting in an electric nded, receiving a nebulizer used observation revealed the dizer mask was located in the electric electrical Nurse (LPN) esident sitting in the electric le bottom of the nebulizer mask tent's mouth. Interview with e of the observation, revealed the dialy 30 minutes prior to the dinued interview with LPN #2 dent had not been assessed for a of medications. SONABLE ACCOMMODATION ERENCES I right to reside and receive difficult in the health or safety of the residents would be their residents would be		246			
	This REQUIREMED by:	ENT is not met as evidenced					<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolute

Event ID: FH1311

Facility ID: TN7505

If continuation sheet Page 2 of 12

8655945739

HEALTH CARE FACILITY

PAGE 06/21 PRINTED: USTINZO 19 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALT	H AND HUMAN SERVICES		·	OMB NO.	938-0391
AND THE PROPERTY OF DESIGNATIONS AND		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	445108	B. WING_	REET ADDRESS, CITY, STATE, ZIP CODE	08/11/2010 E	
NAME OF PROVIDER OR SUPPLIE NHC HEALTHCARE, MURFI			NUNIVERSITY ST MURFREESBORO, TN 37120 PROVIDERS PLAN OF CORREC	TON TON	Oth
[A4] [M] = 4 = 1 A COLORD	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ווע שם טוווע	DATE COMBTELLON (XQ)
F 246 Continued From Based on observialed to provide reach for one (#% reviewed. The findings incl Resident #31 wa August 2, 2008, Dementia, Histo Contractures, Hist	ation, and interview, the facility insure a call light was within at) of thirty three residents admitted to the facility on with diagnoses including by of Deep Vein Thrombosis, pertension, and Chronic Pain. Inimum Data Set (MDS) dated realed the resident had difficulty on term memory, moderate cision making skills, and nice with all activities of daily and dipan. Continued observation at revealed the call light had been ad side table out of the resident's retified Nursing Assistant (CNA 1, 2010, at 9:10 a.m., in the confirmed the resident needed to and the call light was not in the services PROVIDED MEET	F 246	F246 The call light for resident #3 put into the patient's reach u notification to the staff that i accessible to the patient. A patients at that time were ch accessible call lights. In-ser were conducted for nursing on 8/16/10, 8/17/10, 8/23/10 8/31/10. A quality assurance will be conducted by the D0 designee monthly until 1000 compliance is met and then directed by the Quality Ass Committee.	it was not it was not it ecked for rvices partners of and ec study on or her as urance	8/31/10
FORM CMS-2587(02-99) Provious Va	······································	<u>. </u>	Facility (D; TN7505	continuation an	eet Page 3 of

8655945739

HEALTH CARE FACILI..

PAGE 87/21 PRINTED: 08/16/2010 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	PPROVED 3938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:		(X2) M A, BUI		PLE CONSTRUCTION	(X3) DÁTE SƯ COMPLET	RIVEY NED	
		445108	p, Wil			08/11	/2010
	ROMDER OR SUPPLIER ALTHCARE, MURFRE	ESBORO		42	EET ADDRESS, CITY, STATE, ZIP CODE 20 N UNIVERSITY ST JURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	/EACH DEFICIENCS	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SG (DENTIFYING INFORMATION)	ID PREF YAS		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULLO BE	(XS) COMPLETION DATE
F 281	and interview, the findings included residents reviewed. The findings included Resident #12 was a August 11, 2009, was Deficiency Anemia. Atrial Fibrillation, Company of the property of the hemoglobin was greater than 3 physician's order defended every more than 3 physician's order defended every more managed to be administered on July 6, 2010, reveal (reference range 1 was 27.9 (reference r	record review, observation, acility failed to follow the for one (#12) of thirty-three ed; admitted to the facility on fith diagnoses including Iron, Congestive Heart Failure, bronic Kidney Disease, clogical Manifestations, afriy, Anxiety, Depression, and lew of a physician's order revealed the resident was to dication to treat anemia) taneously every three weeks, administer the medication if the eater than 12 or the hematocrit 2. Medical record review of a later and July 19, 2010, revealed the hematocrit were to be of a later and the hematocrit was 9.3 1,5-15.5) and the hematocrit	F	281	F281 The MD was notified of the representation resident # 12 on 8 the medication was disconting the physicians order. An revisually MAR's was conducted unit managers on 8/10/10 to for omitted medications. Integrating missed medication conducted for Licensed Number 100N on 8/10/10, 8/16/10, 8/16/10, and 8/31/10. A quassurance study regarding medications will be conducted monthly for 3 months and the directed by the Quality Associations.	/9/10 and nued per lew of all by the check services as were ses by the /17/10, ality hissed led as	8/31/10

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HEALTH CARE FACIL1

PAGE 08/21 PRINTED: 08/16/2010 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		OMB NO. 0	938-0391		
CENTERS FOR MEDICARE & MEDICARU SERVICES				ŲLTIPL	LE CONSTRUCTION	(X2) DATE SURVEY COMPLETED	
TÄTEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDERSUPPLIEROLIA IDENTIFICATION NUMBER: 44510B		A, BUI				- · [
		B. WI	1G		08/11/	2010	
		7442 100		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1
	NOVIDER OR SUPPLIER			420	O N UNIVERSITY ST		. [
NHÇ HEA	LTHCARE, MURFRE	ESBORO		MI	URFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECT	TION	
(X4) ID {		TEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL	ID PREF	7X	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	DITH GE !	COMPLETION DATE
PREFIX	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAC	• 	OEFICIENCY)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			<u> </u>		· · · · · · · · · · · · · · · · · · ·		
F 281	Continued From pa	age 4		281	•	-	
j	administered on Ju	ıly 29, 2010.		ļ			
!	Observation on Au	gust 9, 2010, at 1:30 p.m.,					
	revealed the reside	ent lying on a low bed, with	İ				
	bilateral floor mats						
	Interview on August 9, 2010, at 2:35 p.m., with Licensed Practical Nurse (LPN) #1, (nurse responsible for the administration of the Procrit on July 29, 2010), in the nursing station, confirmed						
				Ì			
,					•		
	the Procrit was no	t administered as ordered on	ĺ	ľ			
E 074	July 29, 2010. 483.35(i) FOOD P	ROCURE.	 F	371	F371	•	١.
176 1 95≂8	STORE/PREPARI	E/SERVE - SANITARY	ĺ]		 	75 4 7
₩			!		NHC Murfreesboro does maintain the department in a clean and sanitary π	ne dictary	
	The facility must -	rom sources approved of	ļ		lich machine was inspected by Ecol	ab on '	
	considered satisfa	ectory by Federal, State or local	}		8/26/10. A new machine wash temp thermostat and a heating element we	erature ere installed.	, Mis. ,
	authorities; and	, distribute and serve food			Thermostats and gauges were calibr Machine tested at a minimum of 16	ated.	,
	under sanitary cor	nditions			during wash cycle. Machine is world	king properly	· .·.
	!				above minimum 160 degree wash to Continuous monitoring will be mair	mperature.	
	į	•	ļ		ensure proper wash temperatures. A	(II pans of	
					various sizes were checked for wet pulled from shelves and re-washed	nesting and	
	; This REOUIREM!	ENT is not met as evidenced			Another drving shelf was purchased	l and	
	hv		1		delivered on 8/20/10. The two com table was cleaned and all debris rem	partment sink) ,
1	Based on observa	ation, review of manufacturer's interview, the facility falled to	1		the table legs, and along the front &	dge of the	1
	maintain the dieta	ary department in a clean and	İ		lower shelf. The rest of the kitchen for cleanliness on 8/9/10. Staff was	was inspected in-serviced	
	sanitary manner.				on proper cleaning of shelf and sign	ring off on	-
	The findings inclu	ided:	ļ		cleaning list. The steam table in the line was checked for proper temper	e front tray	1
•	ŧ				The pork choos and hamburger pat	ties were rc-	1
	Observation of the	e dietary department on August			heated and then served to the patien services were conducted on 8/10/10	its. In-	
}	; 9, 2010, at 9:30 a i and the Registers	.m., with the Dietary Manager ed Dietitian (RD), revealed the	1 .		PELAICES MOLE PONDITIONED OUT OF LAND	 -	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	dishwasher falled	to reach temperatures	ļ				حسنبل

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLÉ CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
445108		e. WI	NG_		08/11/2010		
	ROVIDER OR SUPPLIER ALTHCARE, MURFRE	ESBORO		4:	REET ADDRESS, CITY, STATE, ZIP CODE 20 N UNIVERSITY ST URFREESBORO, TN 37130		**************************************
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF YAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) GOMPLETION DATE
F 371	degrees F. during the observation revealed reached 155 degrees on August 9, 2010, dishwasher temperate dishwasher indicated should reach 160 decentinued observation of the local continued observation a.m., with the Dietar revealed twenty-sever stacked and second continued observation of the local continued observation of the loca	the manufacturer, of 160 me wash cycle. Continued at the wash temperature es F. Continued observation at 10:35 a.m., revealed the ature reached 150 degrees F. metal plate on the side of the ed the wash temperature egrees F. ion on August 9, 2010, at 9:45 my Manager and the R.D., yen pans, of various sizes,	F	371			
	Manager on August kitchen, confirmed to not reach the manuf twenty-seven pans of and the table had for up on the second (kitchen). Observation of the haugust 10, 2010, at Manager and the Retray line, revealed the Chops and Hamburg recommended hot findegrees F. or above the Front Tray Line, were 130 degrees F.	egistered Dietitian and Dietary 19, 2010, at 10:40 a.m., in the the dishwasher, hot temps, did facturer's recommendations; were stacked and stored wet, rod, moisture, and debris built bower) shelf. not food temperatures on 11:50 a.m., with the Dietary registered Dietitian, of the front the temperatures of the Pork ger Patties were below the cood temperatures of 140 c. Continued observation of revealed the Pork chops 1. and the Hamburger Patties 2. Both the Pork Chops and				• • • • • • • • • • • • • • • • • • • •	
<u>.</u>					···		

FORM CMS-2567(02-99) Previous Versions Obsoleta

Event ID: FH1311

Facility ID: TN7505

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HEALTH CARE FACILITY

PAGE 18/21 PRINTED: 08/10/2010 FORM APPROVED OMB NO, 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			<u> </u>	FORM A OMB NO. 0	938-0391
TATEMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) -PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:	1	IULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
_		445108	B, WI	NG		08/11	/2010
-	ROVIDER OR SUPPLIER	ESBORO		42	EET ADDRESS, CITY, STATE, ZIP CODE 20 N UNIVERSITY ST IVEFREESBORO, TN 37130	•	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREI TAI	.x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ו −שונזונ	OATE COMPLETION
F 371	Interview with the F 10, 2010, at 12:15 department, confir were below 140 de on August 11, 2010 department, confir were served prior to temperatures. 483.60(a),(b) PHA ACCURATE PROC The facility must procure and biological them under an agree served person law permits, but or supervision of a lice. A facility must prove (including procedu acquiring, receiving administering of all the needs of each The facility must each incensed pharmate.	ties were pulled and reheated. Registered Dietitian on August p.m., in the dietary med the food temperatures grees F. Interview with the RD p. at 9:00 a.m., in the dietary med approximately 5 - 7 trays or rechecking the food RMACEUTICAL SVC - CEDURES, RPH rovide routine and emergency als to its residents, or obtain element described in part. The facility may permit held to administer drugs if State also under the general ensed nurse. Vide pharmaceutical services res that assure the accurate g, dispensing, and it drugs and biologicals) to meet resident. Implay or obtain the services of cist who provides consultation are provision of pharmacy	F	425	cont. staff on the cleaning schedule, proper proper for storage of drying pans and monitor items found below standard. The Dicticonduct a QA study on wet nesting, sat food temperatures 3 x week for I month x 2 months, then as directed by the Quantum Assurance Committee. F425 Resident # 12 received her estarting on 7/13/10 to current review of all MAR's was contocheck for missed medicat secondary to not being avail from the pharmacy. A meet the pharmacy was conducted 8/19/10 on procedures for medications not available. It services for licensed nurses conducted by the DON regarmedications not available on 8/17/10, 8/23/10 and 8/31/1 quality assurance study will conducted to check for mediavailability monthly for 3 mand then as directed by the Assurance Committee.	ye drops ti. A nducted ions able ing with d on - were rding a 8/16/10, 0. A be ication nonths	8/26/10 8/31/10
· [by: Based on medical	NT is not met as evidenced record review and observation, ensure a medication was	i i		·		1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PAGE 11/21 PRINTED: 08/16/2010 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	T		OLE SOMETHICTION	(X3) DATE SU	KVEY
TATEMENT ND PLAN O	EMENT: OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION	COMPLETED	
		445108	B. Wil			08/11	/2010
	ROVIDER OR SUPPLIER ALTHICARE, MURFRI	EESBORD		4	REET ADDRESS, CITY, STATE, ZIP CODE 20 N UNIVERSITY ST NURFREESBORO, TN 37130		
14110 1127	<u> </u>				PROVIDER'S PLAN OF CORRECT	TION	. (208)
(X4) ID PREFIX TAG	reac⊎ hericlenc	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IIIIJO BE . 1	DATE CONTINUEN (CR)
F 425	Continued From pa available for one (f reviewed.	age 7 #12) of thirty-three residents	F	425		,	
`	The findings includ	fed;					
- , - - , -	August 11, 2009, v Deficiency Anemia Atrial Fibrillation, C Diabetes with Neu	admitted to the facility on with diagnoses including Iron a Congestive Heart Failure, Chronic Kidney Disease, rological Manifestations, athy, Anxiety, Depression, and		,			
	physician's recapit resident was to red treat allergic conju	riew of the July 2010, tulation orders revealed the ceive Patano! (medication to inctivitis) 0.1% ophthalmic to each eye twice a day.				: " : :::::::::::::::::::::::::::::::::	
	Medication Record circled as not adm 14, 2010, Medical side of the July 20	riew of the July 2010, if revealed the Patanol was ilnistered on July 12, 13, and if record review of the reverse 10, Medication Record revealed "Patanol gits (drops) not from pharmacy."					
F 441 \$S≃D	Licensed Practical responsible for the on July 12, 13, and station, confirmed on July 12, 13, and	N CONTROL, PREVENT	F	441			
	Infection Control F	stablish and maintain an Program designed to provide a comfortable environment and					

FORM CMS-2587(02-99) Previous Votolons Obtoloto

Event ID:FH1811

Facility ID: TN7505

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PAGE 12/21 PRINTED: 08/16/2010 08/17/2010 09:09 HEALTH CARE FACILI. 8655945,54 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES : COMPLETED AND PLAN OF CORRECTION Committee in IDENTIFICATION NUMBER: A. BUILDING B, WING 445108 08/11/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 N UNIVERSITY ST NHC HEALTHCARE, MURFREESBORO MURFREESBORO, TN 37130 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 F 441 Continued From page 8 to help prevent the development and transmission F441 of disease and infection. The CNA that did not wash her (a) Infection Control Program hands after removing her gloves The facility must establish an Infection Control received education on proper hand Program under which it washing on 8/11/10. In-services (1) Investigates, controls, and prevents infections regarding proper hand hygiene were in the facility; (2) Decides what procedures, such as isolation, conducted by the DON for CNA's should be applied to an individual resident; and and Licensed nurses on 8/16/10, (3) Maintains a record of incidents and corrective 8/17/10, 8/23/10 and 8/31/10. A actions related to infections. quality assurance study will be (b) Preventing Spread of Infection conducted by the DON or her (1) When the infection Control Program designee regarding observation of determines that a resident needs isolation to proper hand hygiene monthly for 3 prevent the spread of infection, the facility must · - - - F months and then as directed by the isolate the resident. (2) The facility must prohibit employees with a Quality Assurance Committee. 8/31/10 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

FORM CMS-2587(02-99) Previous Versions Obsoleto

infection.

Personnel must handle, store, process and transport linens so as to prevent the spread of

This REQUIREMENT is not met as evidenced

Based on observation, facility policy review, and interview, the facility staff failed to wash the hands after providing incontinence care for one (#1) of

Event JD; FH1311

Facility (D: TN7505

if continuation sheet Page 9 of 1

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HEALTH CARE FACILI.

PAGE 13/21 PRINTED: UBTIBIZITU FORM APPROVED OMB NG. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	
STATEMENT OF DEPICIENCIES IN FROVIDORS			(X2) M A. BUI		LE CONSTRUCTION	COMPLETED	
	•	445108	8. WIN				1/2010
	OVIDER OR SUPPLIER			42	EET ADDRESS, CITY, STATE, ZIP CODE 20 N UNIVERSITY ST		1
NKC HEA	LTHCARE, MURFRE	ESBORO	_	M	OURFREESBORD, TN 37130 PROVIDERS PLAN OF CORRE	CTION	(XS) COMPLETION
(X4) ID PREFIX TAG	マー・ライト かけだけのでしばい	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD RE	COMPLETION
F 441	Continued From pathirty-three residen	ts reviewed.	F	441			
	revealed Certified providing incontine an episode of feca observation reveal care to the resider and without washing linen from a linen continued observation the resident's revealed CNA #1 without washing the a linen closet, to observation revealed in the line legated in the line.	gust 11, 2010, at 10:20 a.m., Nursing Assistant (CNA) #1 ence care to resident #1, after il incontinence. Continued led after providing incontinence at, CNA #1 removed the gloves ag the hands, obtained clean cart located in the hallway. The allon revealed CNA #1 returned from and placed the clean linen again exited the resident's room and placed the door or obtain a pillow. Continued led there were no pillows in closet and CNA #1 proceeded d pushed the button to go to the apillow.				: *-:	244
	hand " Hand	ility's policy Handwashing s must be washed with soap Before and after assisting Is or toileting"					, .
F 514 SS=D	the Director of Ne confirmed the hall providing inconting proper hand hygi- 483.76(I)(1) RES	ust 11, 2010, at 10:35 a.m., with ursing, in the nursing station, nds are to be washed after ence care, and confirmed ene was not completed. PLETE/ACCURATE/ACCESSIB		F 514	4	,	
	The facility must resident in accord	maintain clinical records on each dance with accepted professiona	i		16	continuation stu	ent Page 10 of

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HEALTH CARE FACILIA

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION. (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: 7 - 5,0 A, BUILDINĠ AND PLAN OF CORRECTION B. WING 08/11/2010 445108 STREET ADDRESS, CITY, SYATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 N UNIVERSITY ST NHC HEALTHCARE, MURFREESBORO MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (25) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) TAG F 514 Continued From page 10 F 514 standards and practices that are complete; F514 accurately documented; readily accessible; and Resident # 12's MD was notified systematically organized. regarding the eye drops. Resident # 12 received her eye drops starting on The clinical record must contain sufficient information to identify the resident, a record of the 7/13/10 to current. A review of July resident's assessments; the plan of care and medication administration records to services provided; the results of any ensure proper documentation of preadmission screening conducted by the State; medications that have been circled and progress notes. on the medication administration record. An in-service was conducted This REQUIREMENT is not met as evidenced by the DON for licensed nurses on by: 8/16/10, 8/17/10, 8/23/10 and Based on medical record review and interview, the facility failed to maintain a complete medical 8/31/10 regarding proper record for one (#12) of thirty-three residents . documentation of held medications. A quality assurance study will be řávlewed. conducted by the DON or her The findings included: designee monthly for 3 months and Medical record review of resident #12's July 2010, then at the discretion of the Quality physician's recapitulation orders revealed the 8/31/10 Assurance Committee. resident was to receive Patanol (medication to treat allergic conjunctivilis) 0,1% ophthalmic solution one drop to each eye twice a day. Medical record review of the July 2010, Medication Record revealed the Patanoi was circled as not administered on July 12, and 14, 2010. Medical record review of the Nurses's Medication Notes, located on the reverse side of the July 2010, Medication Record revealed no documentation why the Patanol was not administered on July 12 and 14, 2010. Interview on August 9, 2010, at 2:50 p.m., with the Director of Nursing (DON), in the conference room, revealed when a medication was circled as

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FH1911

Fecility ID: TN7505

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